THE REGIONAL HOSPITAL
for Respiratory & Complex Care **POLICY**

TITLE: CHARITY CARE
AUTHORIZED: BOARD OF DIRECTORS

POLICY #: BD0006
PAGE: 1 OF
ISSUE DATE: 1/94

Purpose:

To carry out the attached Hopsital Charity Care Policy.

Procedure:

A. Upon admission, determine if other financial resources are available to the patient such as:

1. Group or Individual Medical Plans
2. Worker's Compensation
3. Medicare
4. Medicaid or other State or Federal programs
5. Military (CHAMPUS)
6. Third part liability (auto insurance, personal injury claims)
7. Other resources or proof of ability to pay

B. If none of the above apply, the patient may be considered for charity care. In this case, hand the patient:

1. Charity Care Policy with Notice to Patients (Appendix B)
2. Charity Care Application (Appendix B-1)
3. Application for Charity Care (Appendix B-2)
4. Financial Statement (Appendix B-3)
5. Release of Information (Appendix B-4)

PATIENT MUST SIGN CHARITY CARE APPLICATION ACKNOWLEDGEMENT.

C. To be eligible, the patient must: (1) Return the application and related documents within 14 days. (2) Apply for medical assistance.

Charity Application Flow:

A. Insert signed Charity Care Application into financial ledger and send to Patient Account Manager.
B. Patient Account Manager is responsible to check 14 day return requirement, to maintain files and to ensure timely handling of applications.
C. Administration reviews claims and determines approval or denial.
D. Patient Account Manager notifies patient of decision and monitors appeals.
E. Administration reviews appeals. If denial stays, Patient Account Manager notifies both patient and Department of Health.
F. Records will be retained for 7 years.

Effective Date: 1/94	Reviewed: 5/95JC	Revised: 6/03/97
Related Policies:	Reviewed: 6/01JC	Revised: __/__/__
	Reviewed: 04/03JC	Revised: __/__/__
Submitted: J. CANNON	Reviewed: __/__/__	Revised: __/__/__
Approved: BOARD OF DIRECTORS	Reviewed: __/__/__	Revised: __/__/__

Distribution: BUSINESS OFFICE, MEDITECH

REGIONAL HOSPITAL CHA..TY CARE POLICY

Hospital's Charity Care Mission:

Regional Hospital is committed to the provision of health care services to all persons in need of medical attention regardless of ability to pay without discrimination. In order to protect the integrity of operations and fulfill this commitment, the following criteria for the provision of charity care, consistent with WAC 261-14, are established. Criteria will assist staff in making consistent and objective decisions regarding eligibility for charity care while ensuring the maintenance of a sound financial base.

Eligibility Criteria:

Charity care may be made available after consideration of all other financial resources available to the patient, including group or individual medical plans, Worker's Compensation, Medicare, Medicaid, or medical assistance programs, other State, Federal or military programs, third part liability situation, i.e., auto accidents or personal injuries, or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services.

Patients shall be considered for charity care under this policy based on the following criteria as calculated for the 12 months prior to the date of request.

A. Consistent with WAC 261-14-027, the full amount of hospital charges will be determined to be charity care for any patient whose gross family income is at or below 100% of the current federal poverty guidelines.

B. A sliding fee schedule, Appendix A, will be used to determine amount written off for patients with incomes between 100% and 200% of the federal poverty level. The sliding scale shall be updated annually according to the federal poverty level guidelines published in the Federal Register.

   Patients with an approved adjusted fee are expected to clear their accounts within a satisfactory period of time.

   After review of a personal financial statement, Appendix B, available assets are used to determine elgibility for charity care if family income is greater than 100% of the Federal Poverty Guideline.

Process for Eligibility Determination:

Classification of a patient account balance as charity will be deemed appropriate in those instances where it can reasonably be determined that patient has inadequate financial resources to satisfy medical bills within what would be considered a normal time frame without being subjected to unusually harsh, personal financial constraints.

During patient registration process, RH will make an initial determination of eligibility based on a verbal or written application for charity care. Pending final eligibility determination, RH will not initiate collection efforts or requests for deposits, provided that the responsible party is cooperative with the hospital's efforts to reach a determination of sponsorship status, including return of application and documentation within fourteen (14) days of receipt.

Any one patient or any family unit may apply for Charity Care consideration. Number of claims for assistance is limited to two claims for any one patient or any one family unit per fiscal year. Exceptions will be made on an individual basis through the screening process. Patient may request charity or adjusted fee at any time prior, during or after the course of care for the total bill or a portion of it, except if the account has been assigned to a collection agency.

RH will use an application process for determining initial interest in and qualification for charity care, Appendix B.

Charity care forms, instructions, and written applications shall be furnished to patients when charity care is requested, when need is indicated, or when financial screening indicates potential need. All applications need to be accompanied by one or more of the following documentation to verify income amounts indicated on the application form.

1. W-2 witholding statements for all employment during the last 12 months.
2. Pay stubs from all employment during the last 12 months.
3. Income tax return from the most recently filed calendar year.
4. Forms approving or denying unemployment compensation.
5. Written statements from employers or welfare agencies.

Patients need to apply for Medicaid or Medical Assistance and need to provide within fourteen (14) days forms approving or denying eligibility for Medicaid and/or state funded medical assistance programs.

All applications, support documentation and financial verification forms will be gathered by the Patient Account Manager and will accompany the patient account ledger to administration.

Approval/Denial:

RH will provide final determination within fourteen (14) days of receipt of all application and documentation material, Appendix C.

If it is determined that a patient has financial resources which can be used to satisfy the medical liability, but demonstrates an unwillingness to do so, charity application will be denied.

Denials will be written. Patient may appeal denial by providing additional information to the Patient Account Manager within fourteen (14) days of receipt of denial notification. All appeals will be reviewed by the Administrator. If determination affirms previous charity care denial, written notification will be sent to patient and Department of Health in accordance with state law.

Confidentiality:

All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form. All records will be retained for seven (7) years.

Public Notification:

Charity care policy is publicly available through posting of signs in patient registration areas and distribution of written materials indicating policy to patients at the time the hospital determines third party coverage. Non-English translations of this document will be made available if a specific group of more than 10% of the population in the service area speaks the language.

Notice to Patients:

The Regional Hospital for Respiratory & Complex Care is committed to the provision of health care services to all persons in need of medical attention regardless of ability to pay and without discrimination.

Eligibility for Charity Care:

Charity care may be made available after consideration of all other financial resources available to the patient such as group or individual medical plans, Worker's Compensation, Medicare, Medicaid, medical assistance programs, other State or Federal programs, military programs and third party liability.

Eligibility Determination:

Obtain from the registration clerk or discharge office a Charity Care application. You must return a fully completed application within fourteen (14) days of receipt.

Notification:

You will be notified in writing if charity care is approved or denied. If denied, an appeal process is available to you.

Charity Care Application

Attached are:

1. Application for Charity Care
2. Financial Statement
3. Release of Information Form

All forms must be fully completed.

I understand that charity care may be made available only after all other financial resources available to me are exhausted.

Please answer the following:

My injury or illness is work related.	Yes	No
I was treated because of an auto accident and coverage is available through my or the other party's insurance.	Yes	No
I have hospital insurance.	Yes	No
I am unemployed.	Yes	No
I am covered by a Cobra program through my last employer.	Yes	No

I understand that I must apply for Medicaid/Medical Assistance.

If you are an inpatient, the hospital will assist you. If you are an out patient, you must apply in person at the nearest Department of Health Services Community Service office.

In order to be eligible for charity care, you must have received a denial for medical assistance within two (2) weeks of today.

It is very important you apply immediately and furnish all the information asked of you by DSHS in a timely manner.

ALL FORMS, DOCUMENTATION, MEDICAL ASSISTANCE DENIAL LETTER MUST BE RECEIVED WITHIN FOURTEEN (14) DAYS AFTER TODAY.

Patient Acknowledgement: Date: _____ Time: _____

_____

Patient's Signature

Registration Clerk, provide a copy to patient and insert original in the Patient Account Ledger.

NW Regional Hospital **Appendix B-2**

Application for Charity Care

Patient Name:_____Admit Date:_____

Address:_____Discharge Date:_____

_____

Phone: Home_____ Work_____

Reason for Hospitalization:_____

_____

Total Hospital Charges: $_____

What portion of your hospital charges is paid by other health insurance:

$_____

List all physicians involved in your hospital care.

_____ _____

_____ _____

List total medical and dental expenses for the last 12 months, not including this admission:_____

_____

(Use other side of paper if needed.)

If unemployed, please state how you have been supporting yourself, i.e., Unemployment benefits, Welfare, etc.

_____

_____

List the reasons why you are applying for charity care:

_____

_____

_____

_____

_____ _____

Signature Date

To Whom It May Concern: Appendix B-4

I, _____, authorize the Service Center
(Name of Applicant)
Office of the Department of Social and Human Services to release information concerning my application to The Regional Hospital for Respiratory & Complex Care at the above address.

_____ _____
Signature of Applicant Date

RELEASE OF INFORMATION FORM FOR MEDICAL ASSISTANCE PROGRAM